NURSE AGENCY APPLICATION

Illinois Department of Labor
Equal Opportunity Workforce Division - Licensing Section
160 North LaSalle Street, Suite C-1300
Chicago, Illinois 60601-3150
Telephone #: (312) 793-2810 - Facsimile #: (312) 793-5257

Office Use Only

Date Rec'd:

Type of Application (check one): ☐ New or ☐ Renewal	Type of Application (check one): ☐ Primary Location or ☐ Additional Location

APPLICATION IS HEREBY MADE ON BEHALF OF:

☐ Corporation ☐ LLC ☐ LLP ☐ Sole Proprietor ☐ Partnership	Name of Corporation, LLP, LLC, if applicable:	
	Name of Partners or Sole Proprietor, if applicable:	

Expiration:

NAME AND ADDRESS UNDER WHICH BUSINESS WILL OPERATE:

Business Name:					
Business Address:				County:	
City:		State:		Zip Code:	
Telephone #:		Facsimile #:			
If new address, date moved:		FEIN/SS#:			
Has this Nurse Agency ever been licensed under another name? If yes, please provide name(s):				☐ Franchise _____ Date Purchased:	

Fee Rec'd:

CHECK ONE:	☐ President	☐ Sole Owner	☐ Partner (see page 3 bottom)
Name:			
Residence Address:			SS#:
City:		State:	Zip Code:
Telephone #:		Facsimile #:	
Have you, as Principal Officer, ever been convicted of a felony? If yes, please explain on a separate sheet of paper:			☐ Yes ☐ No

Ck#:

PROOF OF PROFESSIONAL LIABILITY INSURANCE IN THE AMOUNT OF $1,000,000 AGGREGATE AND $500,000 PER INCIDENT MUST BE ATTACHED TO THIS APPLICATION FORM:

Professional Liability Carrier (Insurance Company Name):			
Name of Insurance Agency:		Telephone #:	
Policy Number:		Policy term dates: from _____ to _____	

File#:

LIST THE NUMBER OF EMPLOYEES REPORTED ON YOUR LAST QUARTERLY UI3-40 FORM, OR IF THIS IS A NEW APPLICATION, LIST THE ANTICIPATED REFERRALS FOR NEXT QUARTER.

RNs:		LPNs:		CNAs:	

PROVIDE THE FOLLOWING PERSONNEL RESPONSIBLE FOR:		
	NAME	**TITLE** (License # if applicable)
Assignments or Referrals to Health Care Facilities:		
If individual listed above is not RN, list RN who oversees the assignments:		
Hiring/Firing of RNs, LPNs and CNAs:		
Verifying Licensure or Certification Status:		
Evaluating Performance of RNs, LPNs and CNAs:		
Conducting Personal Interview of Applicant:		
Responding to Complaints from Health Care Facilities:		
Recruitment of RNs, LPNs and CNAs:		
Signing of Payroll Checks:		
Acquiring Line of Credit:		
Signing for Insurance:		

Supervising Registered Nurse (RN): _____ Date appointed: _____

A current copy of **both** the registered nurse's license and verification printout from the Illinois Department of Professional Regulation must be attached.

Person who is to have management of the Nurse Agency:	

TYPE OF FACILITIES / CLIENTS SERVED (Check all that apply)**:**

☐ Hospitals	☐ Kidney Disease Treatment Centers	☐ Nursing Homes	☐ Health Maintenance Organizations	☐ Ambulatory Surgical Treatment Centers

LIST TWO MOST RECENT HEALTH CARE FACILITIES TO WHICH YOU HAVE MADE REFERRALS OR, IF THIS IS A NEW APPLICATION, THOSE TO WHICH YOU INTEND TO MAKE REFERRALS.

Name of Facility #1:					
Contact Person:		Telephone #:			
Street Address:					
City:		State:		Zip Code:	
Name of Facility #2:					
Contact Person:		Telephone #:			
Street Address:					
City:		State:		Zip Code:	

IF NECESSARY, ATTACH ADDITIONAL SHEETS TO PROVIDE THE FOLLOWING INFORMATION. List corporate officers (excluding president):			
Name:		Name:	
Title:		Title:	
Residence:		Residence:	
City, State, Zip:		City, State, Zip:	
Name:		Name:	
Title:		Title:	
Residence:		Residence:	
City, State, Zip:		City, State, Zip:	
IF NOT COMPLETED FOR CORPORATION, APPLICATION WILL NOT BE PROCESSED. List Officers, Directors and Shareholders owning more than 5% of the corporation's stock. (Attach additional sheets if necessary):			
Name:		Name:	
Residence:		Residence:	
City, State, Zip:		City, State, Zip:	
% Stock Owned:		% Stock Owned:	
Name:		Name:	
Residence:		Residence:	
City, State, Zip:		City, State, Zip:	
% Stock Owned:		% Stock Owned:	
LIST BOARD OF DIRECTORS.			
Name:		Name:	
Residence:		Residence:	
City, State, Zip:		City, State, Zip:	
Name:		Name:	
Residence:		Residence:	
City, State, Zip:		City, State, Zip:	
LIST ADDITIONAL PARTNERS.			
Name:		Name:	
Residence:		Residence:	
City, State, Zip:		City, State, Zip:	

LIST ANY OTHER BUSINESS OWNED OR OPERATED IN WHOLE OR IN PART.

(Attach an additional sheet if necessary):

☐ Private Employment Agency	Name:	
	Address:	
	City, State & Zip:	
	Telephone #:	
☐ Home Health Care Agency	Name:	
	Address:	
	City, State & Zip:	
	Telephone #:	
☐ Other (please specify)	Name:	
	Address:	
	City, State & Zip:	
	Telephone #:	

STATEMENT OF FINANCIAL SOLVENCY:

For the purpose of meeting the requirements of the Nurse Agency Licensing Act (225 ILCS 510/1-15), the Nurse Agency Applicant hereby states and declares:

1. That within the last seven (7) years the Nurse Agency and/or its owners have not been adjudged insolvent or bankrupt in a State or Federal court; and
2. That a court proceeding to make a judgment of bankruptcy or insolvency with respect to the Nurse Agency and/or its owners is not pending in a State or Federal court; and
3. That the Nurse Agency and/or its owners are able to pay any and all debts as they become due and owing.

In addition, the Nurse Agency agrees to inform the Director of the Illinois Department of Labor prior to a court proceeding to make a judgment of insolvency or bankruptcy, which will be instituted with respect to the Nurse Agency or its owners.

Check one only:	☐ Sole Owner	☐ Partner	☐ Authorized Corporate Officer	☐ Manager

× _____ Signature:

_____ Name (typewritten):

_____ Title:

_____ Date:

The undersigned certifies that s/he has read and understands the contents of this application and shall abide by all terms and conditions stated in any part of the form (instructions, filing requirement and licensing information) and that the undersigned is AN OWNER OR MANAGER of the business and is sufficiently familiar with the ownership, management, control and other aspects of the business to accurately and completely fill out the form. Further, the undersigned swears or affirms that the information provided is true and current at the time of the signing and that the person signing is authorized to do so.

The undersigned also certifies that the Nurse Agency is in compliance with State and Federal laws relating to employee compensation, Social Security taxes, State and Federal income taxes, worker's compensation, unemployment taxes and State and Federal overtime compensation laws.

Check one only:	☐ Sole Owner	☐ Partner	☐ Authorized Corporate Officer	☐ Manager

× _____ Signature:

_____ Name (typewritten):

_____ Title:

_____ Date:

Subscribed and sworn to before me this _____ day of _____, _____.

Notary Public